Bedstone Limited

The Hockeredge

Inspection report

2 - 4 Canterbury Road
Westgate-on-Sea
Margate
Kent
CT8 8JJ
Tel: 01843 831585

Date of inspection visit: 16 and 20 July 2015
Date of publication: 11/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection that took place on 16 and 20 July 2015.

The service provides accommodation with nursing and personal care for up to 47 people, some of whom may be living with mental health and dementia related conditions. Bedrooms are on the ground and first floor and are all single occupancy. There is a lift to the first and second floors. There are communal lounges, a dining room and activity areas on the ground floor. There is a garden to the rear of the property. There were 42 people living at the service when we inspected.

There was no registered manager when we visited. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A number of shortfalls were identified during our visit, some of which had been recognised by the provider. An action plan was in place with timescales and named staff that would be responsible for making these

Summary of findings

improvements. The operations director was overseeing the management and running of the service and was supporting staff to make the improvements. However, there was still work to be completed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There were restrictions imposed on people that had not been assessed, consented to and reviewed to be the least restrictive option. This included a locked door policy and managing people's cigarettes. DoLS authorisations had started to be applied for to the local authority but there had been a delay in ensuring they were applied for when people were having their liberties restricted unlawfully. When people lacked the capacity to make decisions staff were not following the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. The administration of covert medicines had not been assessed to ensure this was the best way to ensure people received their medicines.

People were at risk of not having their health care needs met. Wound care treatment plans were not completed so people's skin was not monitored effectively to prevent the risk of further breakdown. Some people did not have the support they needed to manage their continence. Some people had diabetes and needed their blood sugar levels monitoring. This was not happening.

People could choose from a range of different meals and specialist diets were catered for. However, people who had lost weight should have a treatment plan to help improve their weight. These were not always in place and some people continued to lose weight.

Management of risks was inconsistent and risk assessments were not all up to date to give staff guidance of how to manage some risks safely. Accidents and incidents were recorded, but not monitored, reviewed or analysed to prevent or reduce the likelihood of reoccurrence.

People's care needs were not always assessed before they moved in. Care plans had not all been reviewed and kept up to date to ensure that staff were aware of people's current needs. There was an action plan in place to address this, but this work was still in progress.

People and their relatives thought that staff made sure they were kept safe, although some relatives did have concerns that some people could get agitated at times and this could have a negative impact of their relatives. Staff understood the importance of monitoring people to ensure that other people were not put at risk. Staff had a good awareness of what abuse was and knew about the importance of whistle blowing.

Routine prescribed medicines were managed safely and people received their medicines when they needed them. The records for the returned / destroyed medicines were not properly maintained and there were no protocols for 'as and when' (PRN) medicines.

There were shortfalls in staff training and not all staff had received supervision. There was an action plan in place to address this and a staff supervision programme was in place. Staff felt well supported and had the opportunity to attend regular staff meetings. Recruitment checks were carried out for new members of staff.

There were enough staff on duty to meet people's physical needs, although staff were busy and did not have much time to spend with people. Staff did not always notice that people needed support to go to the toilet.

There were some processes to support people to have a say about the service and give their opinions, but these were not consistently in use. There were limited opportunities for people to take part in different pastimes, although they could choose from some arranged activities available.

Audits were not carried out to make sure the quality of the care provided was monitored, assessed and reviewed. Records were kept about the care people received and about the day to day running of the service. Some records were not accurate and were not always up to date.

There was an on-going refurbishment programme. There was a lack of suitable signage to help people find their way around. There were risk assessments and safeguards to keep people safe in the environment.

There was a complaints procedure. People and their relatives felt confident that any concerns they had would be acted upon and resolved.

The provider had a clear vision for improvements for the service and was supporting staff by providing additional resources to make improvements.

Summary of findings

We have made recommendations that the provider consider best practice guidance for the environment and developing activities for people living with the dementia.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 You can see what action we told the provider to take at the back of the full version of this report.

We have issued two formal warning notices to Bedstone Limited telling them they must take action to address the safe care and treatment of people and the good governance systems in the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not consistently safe.

Risk management plans did not give staff guidance in order to minimise identified risks.

Staff did not always have time to respond to people's needs.

There were systems in place to recruit new staff.

People's medicines were managed and stored safely. There were no clear guidelines for 'as and when' or covert medicines.

People were supported by staff who understood how to report and recognise any concerns. Any allegations of abuse were taken seriously and responded to appropriately.

Is the service effective?

Inadequate 

The service was not effective.

There were some restrictive practices which deprived people of their liberty, these had not always been assessed and authorised. Mental capacity assessments were not meeting the requirements of the Mental Capacity Act 2005.

People were not supported with their health care needs to ensure they were well and healthy.

Staff had not received all the training and supervision they needed to give them the skills and knowledge to provide effective care.

People were given a range of choices of different meals. However, people who lost weight were not given the care and treatment they needed.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Not all staff members communicated well with people.

People were not always actively supported to be involved in identifying what their likes, dislikes and preferences were. Care plans lacked personalisation.

People liked the staff who were caring for them and staff understood how to protect people's privacy and dignity.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's individual care needs were not always assessed and planned properly, although staff knew what support people needed.

Summary of findings

People had some opportunities to take part in activities; an action plan was in place to further develop the activities programme.

There was a complaints procedure and people were confident that any concerns would be acted upon and resolved.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

There was no registered manager, however the operations director was overseeing the service and had a clear vision of the improvements needed.

Quality assurance systems were not being followed as audits were not being completed.

Records about the care people received were not accurate and up to date.

There were some processes to gain people opinions about the service, but these had not been fully developed.

Staff felt well supported and knew that improvements were needed.

The Hockeredge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 20 July 2015 and was unannounced. The inspection was carried out by one inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service and had specialist knowledge of people living with dementia.

We did not ask the provider to complete a Provider Information Return (PIR), as we carried out this visit at short notice because we had received concerns about the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

During our inspection we spoke with seventeen people using the service, eight relatives or friends, nine members of staff, the deputy managers, the manager and the operations director.

We observed the lunch time meals and observed how staff spoke with people. We looked around the service including shared facilities and in people's bedrooms with their permission. We looked at a range of records including the care plans and monitoring records for eight people, medicine administration records, staff records for recruitment and training, accident and incident records, records for monitoring the quality of the service provided including audits, complaints records and meeting minutes.

The last inspection took place on 9 May 2014. There were no concerns identified.

Requires improvement

Is the service safe?

Our findings

People's views about their safety were mixed. One person said, "Sometimes they leave me, and forget I am in my room" and another person was concerned that they may be asked to leave. Other people we spoke with told us they felt safe and commented, "Oh yes, absolutely safe. Nobody has threatened me yet" and "It is all safe".

Relatives had mixed views about the safety of their loved ones. Some relatives were concerned because they felt that there was a risk that aggressive incidents might happen. One relative told us that they relied on staff to cope with incidents. Another relative said, "I do get concerned about the residents who wander into other people's rooms and the carers can't be everywhere". Other relatives said they felt staff made sure people were kept safe. Relatives commented, "He is safe and settled there and I wouldn't want him moved at all", "Most definitely safe" and "I do worry about him but not because of the home. They are very good and he is as safe as he can be".

Some people had mental health conditions which could cause them to become unsettled and agitated at times. Risk assessments for supporting people with behaviours that challenged provided limited guidance to enable staff to minimise risks to people. There had been a number of verbal and physical incidents involving one person. Following the last incident there had been a meeting for staff who had been involved to reflect how the incident was managed and to look at how best to manage any future incidents. The risk assessment had not been updated to reflect the outcome of this meeting and did not include the changes suggested to the person's support. Staff spoke about how to recognise the potential risks but had different strategies for managing situations with this person which led to an inconsistent approach.

Staff were not always sure about how to handle different situations. One person became unsettled and agitated during our visit. Although the staff present handled the situation calmly, some staff did not know what to do when this person laid down on the floor and refused to get up and had to get the support of other staff to help this person get up. Another person became agitated, but staff supported this person in a calm manner and reassurance was offered immediately, this person soon became settled.

Risk assessments provided limited guidance to give staff a consistent approach to minimise risk. In some cases risk management plans for identified risks had not been developed. For example, there was a risk assessment for one person that identified what the risk was, but there was no information about how to reduce or manage the risk. Other risks were identified such as risks to people's nutritional needs, skin care and mobility, but there was not always a risk management plan in place to reduce the risk to the person so increasing the potential for the person to be at risk from harm . There were some 'blanket' risk assessments in people's records about locked doors and the risk of using bed rails. These had not been updated since they had first put in place when people moved into the service. A risk assessment had been carried out in 2011, but had not been reviewed to make sure it was still relevant and appropriate to the person and ensure it was still necessary.

Following incidents and accidents, reflective practice meetings took place with the staff who had been involved to review what had happened and to see what 'could be done better next time'. Staff told us that this was useful and helped them to find improved ways of supporting people safely. However, accidents and incidents were not monitored, reviewed and assessed to look for any patterns and causes. Accidents and incidents were recorded in an accident book or on an incident form. These were then filed away and the accident reports did not show what had been put in place to prevent or reduce the likelihood of reoccurrence. The manager confirmed that there was a system for auditing and reviewing accidents and incidents so they could be analysed, but these had not been completed since January 2015. By not reviewing and analysing accidents and incidents, people were being put at risk of events reoccurring.

The provider had failed to make sure that risks to people staff and others had been managed to protect people from harm and ensure their safety. This was a breach of Regulation (12)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks assessments about hazards to people posed by the environment and equipment were in place. The service was undergoing a major refurbishment programme which was being completed in stages. This resulted in some areas of the building being unsafe at times because of the improvement works. There were risk assessments in place

Is the service safe?

to protect people from the risk of harm. There were procedures in place for emergencies and appropriate checks had been carried out with regards to gas and electrical equipment. Fire exits in the building were clearly marked and were free from obstruction. There were emergency evacuation plans in place for people. Some staff had been nominated as fire wardens and had been booked onto a training course.

There was a mixture of staff employed at the service including registered mental health nurses as well as registered general nurses and care staff which gave a mix of skills and competencies. As well as the care staff there were additional support staff including administration, kitchen and domestic staff and staff responsible for activities.

There were two nurses and eight care staff during the day, with one nurse and four care staff at night for up to 47 people using the service at any one time. We asked how staffing levels were calculated. The manager said that the current staffing levels had been established for some time and had not been changed. There was a dependency assessment tool in place, which was being reviewed to ensure that staffing levels were being assessed correctly.

People and their relatives had mixed views about the amount of staff on duty. Some people thought there were not always enough staff to meet their needs, while other people thought there were always 'plenty of staff'. One person was repeatedly calling out, but there were no staff in the area to answer them. Another person told us, "It is always like this, they can't get staff". One person said, "I sometimes have to wait quite a while for them to answer my (call) bell". A visitor told us, "They can be short staffed, although they do all they can". We were told that there should always be a member of staff on duty in the main lounge area. During our visit we spent time in this area and noted that this was not always the case. This was because staff were called away to assist other members of staff to help people to the toilet or were supporting people to go outside for a cigarette. Staff answered calls promptly most of the time but there was an occasion we observed when a person needed to go to the toilet. Staff had not noticed that this person needed assistance because they were busy elsewhere.

The provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs at all times. This was breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to recruit new staff. A recent recruitment drive had resulted in a number of new staff being employed. This included both care staff and qualified nurses and meant that agency staff were no longer needed to supplement the staffing levels. A recruitment agency had been used to employ some nurses and they carried out the checks needed to make sure staff were suitable to work with people. Nurses' pin numbers were checked to ensure they were fit to practice. Most of the documentation required by law such as employment histories, proof of identity, references and a Disclosure and Barring Service (DBS) check were in place. An audit had been carried out of staff files and it had been recognised that there was some documentation missing. Action had been taken to follow this up and ensure that all the correct documentation was in place.

Staff knew about different types of abuse and how people could be at risk. There were systems in place to safeguard people including a policy and procedure which gave staff the information they needed to ensure they knew what to do if they suspected any incidents of abuse. Staff knew where the policies and procedures were kept and how to access them. Staff described what different types of abuse were including discrimination, financial and physical. Staff told us how they would raise any concerns if they were worried about people's safety. Staff said, "I would go to the manager. There are also senior managers and we can ring you (the Care Quality Commission) or the local authority" and "We report anything straight away. I know anything I report would be acted on".

When any concerns had been raised about people's safety, including any incidents between people, these had been reported to the local authority safeguarding team. Staff worked with the safeguarding team to address any concerns.

Staff said they knew what the whistleblowing processes were and informed us that they would not hesitate to report any concerns to the manager. Staff told us they felt

Requires improvement

Is the service safe?

supported and could speak to a senior member of staff or a manager. Disciplinary and poor practice procedures were followed to make sure actions were taken to address any issues which had been identified.

People were not able to manage their own medicines, so medicines were administered by the nurses. Nursing staff knew about 'as and when medicines' (PRN), but there were no protocols in place to give guidance on when medicines should be offered relating to individual needs to ensure that these medicines were administered appropriately. Some people refused to take their medicines and these needed to be administered covertly so that people's health did not deteriorate. Covert is the term used when medicines are administered in a disguised format, for example, in food or in a drink. There were no clear guidelines for people who needed to have their medicines administered in this way to ensure this was in their best interest.

A new clinical room had just been completed which gave nurses an improved area to store and manage medicines. Medicines were stored in the clinical room in either locked cabinets or cupboards. Most medicines were administered using a monitored dosage system, which organises medication separately for each person. Medicines stored outside of this system were stored on shelves in the medication trolley or in locked cupboards or fridges. Bottles of medicines, packets of tablets and eye drops were dated when they were opened. Each dose administered was recorded on a medicines administration record (MAR chart). The MAR charts had been accurately completed. Medicines used for pain relief were given when people were in pain rather than on a regular basis so people only had their medicines when they needed them.

People told us they got their tablets when they needed them and at the right times. Two people told us that they 'suffered from aches and pains' but staff always gave them a painkiller when they asked for them.

Inadequate

Is the service effective?

Our findings

People thought staff were 'good' and that they were 'helpful'. One person said, "They are very calming" and another person told us, "They do things for me". Most relatives stated that staff understood their loved ones conditions, with one relative saying, "They always deal with things and come up with solutions" and another stated, "(My relative) is kept comfortable and he is getting the care he needs". Some relatives felt that care staff did not always know about their loved ones conditions, but told us that all staff had 'empathy' and knew people.

People were at risk of not having their rights upheld if they lacked capacity or had fluctuating capacity. There was a lack of understanding about the Mental Capacity Act (MCA) 2005 and the implications for people who used the service. When people moved in a 'determination of capacity' was carried out. This was a 'two stage test' to see if people had the capacity to make certain decisions. This included assessing the ability to consent to personal care, locks on bedroom doors, if people smoked and any issues around medicines. These were carried out by a senior member of staff, with no input from the person, health care professionals or relatives. These assessments were not decision specific but general and had not been reviewed since people moved in, in case there had been any changes. The assessments were used to make decisions about how people would be supported without people being involved. The MCA states that any assessments should be decision specific and not general and reviewed on a regular basis.

Following the 'determination of capacity' assessment some people had their medicines given to them hidden in food or drink, as they refused to take these medicines in a tablet or liquid form. This was known as covert administration of medicines and although medicines were administered in this way, to keep people healthy, there were no systems in place to support why these decisions had been made. When people are not able to make complex or other decisions a mental capacity assessment should be carried out and a best interest meeting held, if necessary, which should include all relevant people associated with the decision. There had been no best interest meetings held for people who had been assessed as needing to have their medicines given covertly.

Some decisions had been made which had put restrictions on people's freedom to make informed choices. For 'health and safety reasons' no one was allowed to keep their own cigarettes and they needed to ask staff when they wanted to have a cigarette. Although staff took people into the garden for a cigarette when they asked, no one had been individually assessed to see if they could manage their own cigarettes safely. People's capacity to make these decisions had not been assessed and people had not been given the opportunity to be part of this decision contrary to the MCA.

A lot of the bedroom doors were locked during the day so people could not access their rooms without staff. Staff told us that this was because some people could go into other rooms without being asked or invited. Staff said that three people had keys to their own rooms so could get into their rooms when they wanted to. Other people could not. There were bedroom risk assessments in place, but some of these were out of date and indicated people had keys to their rooms when they no longer had these. There were no capacity assessments or best interest meetings in place to demonstrate that these decisions had been made in people's best interests.

Staff knew and understood how to support people with making daily living decisions, such as when they got up and went to bed, what they wanted to wear and what they wanted to choose for their meals. Staff, however, had limited understanding of MCA legislation and how to apply in 'day- to -day' practice. Records about capacity and consent were confusing and contradictory. For example, the mental capacity assessment for one person completed by a senior member of the nursing team stated that the mental capacity of this person had not been assessed by a professional person. It identified that the person could not understand, retain, weigh up or communicate a decision. The 'personal hygiene' support plan for the same person stated 'can communicate most needs verbally. He is able to understand most things that are said to him about his day-to-day needs'. This directly conflicted with the outcome of the mental capacity assessment leading to a risk that the person would not have the support they needed to make decisions.

The provider did not have proper procedures in place to act in accordance with the MCA and to obtain consent from people for care and treatment. This was a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

The lack of understanding about mental capacity had a direct impact on potential deprivations of liberty. There was a culture of some restrictive practices in the service with blanket decisions being made for everyone including the locked door policy and the limited access to cigarettes. Staff lacked understanding about the management of Deprivation of Liberty Safeguards (DoLS) and implications for people. The management team had arranged for DoLS applications to be made and were prioritising people they had assessed as being a higher risk of having their liberty deprived unlawfully. This included the people who were having their medicines administered covertly, even though this was not a reason to make an application for a DoLS authorisation. One member of staff said they knew about submitting a DoLS application and also about an 'urgent authorisation' which could be implemented by the managing authority (which was the care service). They did not, however, know what to do if the urgent authorisation expired before a full DoLS authorisation was granted. Some staff did not know if anyone was affected by DoLS legislation and the impact on their care. A senior member of staff said that a DoLS authorisation had been received for one person in June, but this had not been looked at to ensure the person was not being restricted unlawfully.

DoLS applies to care homes. These safeguards should protect the rights of people using services to make sure that any restrictions to their freedom and liberty have been applied for and authorised by the local authority. This includes if a person lacking capacity to consent to arrangement for their care, is subject to continuous supervision and control, by needing support with all or most everyday tasks and is not free to leave the service; they are likely to be deprived of their liberty. These authorisations should be made as soon as any potential restrictions are identified and any recommendations should be acted on. There was a lack of understanding about what 'depriving people of their liberty' was.

People were not protected against being restricted unlawfully. This was a breach of Regulation 13 (5).

People were at risk of not having their health care needs met. The pre-admission assessment identified some health care needs for people, but there was a lack of guidance for staff in care plans to show how to meet these needs. For example, one person suffered with epilepsy, but their 'physical health' care plan provided only very basic instructions about how to support them if they had a seizure. There was no guidance for staff about possible triggers to seizures and what actions to take. Staff reported that this person had had a number of seizures since moving in. There was a seizure recording chart but none of the seizures had been recorded on it.

Some people suffered with diabetes. On admission a person had been identified with type two diabetes, which is when people do not produce enough insulin and can cause health problems. There was no care plan in place to state how the person's condition would be monitored and how the person would be supported. A nurse stated that the person's condition was medication controlled and required no further input. The person required their blood sugar levels to be checked. However, there were no blood monitoring records available and their condition was not mentioned in the medication or eating and drinking care plans. A nurse told us that people who were diabetic should have their blood sugar levels checked very Tuesday and Friday. We looked at the records for another two people who needed their blood sugar levels checked on a regular basis. The nurse told us and the care plan's confirmed that the normal range should have a reading of between four and seven. Not all the blood sugar levels had been recorded. The available records showed that between 8 May and 19 June 2015 only one of the readings for one person and none of the readings for the other person were within the recommended range as described in the care plan. We asked what happened when people's blood sugar levels were not within this range. The nurse told us that people should be given extra drinks, possibly have their urine checked and then their blood sugar levels should be re-taken. There was no guidance in the care plans to tell staff what to do and there were no records to show that this had happened.

Some people needed support to manage their continence. One person had been referred to the continence nurse in June 2014. Staff had recorded a follow up request in August 2014 and June 2015, but no further action had been taken to support this person to manage their continence. There was no plan in place to help manage this person's continence and as a result the person did not have the right support to manage their continence. The care plan stated this person was continent, but had been written in 2013. Staff told us that this person often had accidents and needed a change of clothing 'several times' a day. We observed that this person was wearing wet clothing for most of the morning on one of the days of our visit.

Inadequate

Is the service effective?

Some people's skin had broken down and they had pressure sores. Healthcare professionals had visited previously and identified that staff were not recording or monitoring pressure area care. They had given staff advice about how to manage and record treatment around people's skin conditions. Although people's skin conditions were not deteriorating and wound care treatment plans were in place, these were not being consistently completed. One person had been identified as being 'very high risk' on their skin integrity assessment, but this had not been reviewed since August 2014 to ensure they were not at further risk. If people's skin care was not monitored effectively for improvement, there was a risk of further breakdown.

Some people had been identified as at risk of losing weight. Staff told us that when people lost weight they were put on a treatment plan which included offering additional fortified and nutritious snacks and milkshakes. Staff told us that people should also be placed on food and fluid charts to monitor their intake and be weighed within two weeks. Staff told us if there was further weight loss then additional actions would be taken such as contacting the dietician. These actions were not always being taken when a person had lost weight. One person had lost weight, but there was no written treatment plan to guide staff. There were no food and fluid charts to monitor their intake, and observations during the morning of our visit showed they were not offered additional fortified snacks. This person had continued to lose weight. Staff were not monitoring the food charts which were in place to check people were getting enough to eat.

Relatives had mixed views about how their loved one's health care needs were managed. One relative told us, "(My relative) is being looked after but his skin is breaking down as he doesn't move much. He has a sore on his ankle and has had it quite some time. I always ask the carers about it". They told us they did not know what was happening with the management of this wound. Another relative told us that they had not been made aware of a hospital appointment their relative was attending.

Communication between staff was not effective. Information in handover records was not always updated into people's care plans. Changes in people's needs were not always shared to ensure people were supported and safeguarded against any risks associated with their care needs.

The provider had failed to make sure that care and treatment was provided in a safe way. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had carried out an audit of staff induction, training and supervision. Shortfalls had been found in all these areas. Staff completed the in-house basic and foundation induction when they first started. However, it had been recognised that this needed improving. The service had accessed the new Care Certificate. This is a set of standards that sets out the learning outcomes, competences and standards of care expected by staff working in the care sector. It had been developed by Skills for Care, who are an organisation that work with social care employers to help deliver high quality care. There was a programme in place for both nurses and care staff to complete this.

There were gaps in staff training and not all staff had completed the training they were required to undertake. There had been a full audit and review of the training and the outstanding training needs had been identified. There was a training plan in place and staff were being allocated places on these sessions. Training was now taking place on a weekly basis and staff were reminded of these sessions through staff meetings and notices. Senior staff had been given roles as mentors in different areas to support other staff to develop their skills and knowledge. Some staff lacked the skills to support people properly when they displayed behaviours that may challenge. For example staff did not know how to support one person when they became agitated.

A new nurse competency assessment had been introduced, but not implemented so none of the nursing staff had had their competencies checked. Nurses were not always following procedures to ensure people's health care needs were addressed including not recording wound care treatment or ensuring people received the right care if there was a change in their health. Therefore the provider could not be assured that nurses were competent to carry out their role. There were timescales for this to be completed to ensure that the nurses had the skills to carry out their role safely.

Supervisions had started to be carried out. The operations director had taken the lead for the supervisions and there was a schedule of meetings arranged with individual staff. At our visit approximately a third of staff had been given

supervision. Staff were given support at team meetings and areas for improvement were discussed at these meetings. Staff who had taken part in reflective practice meetings felt these were 'useful and informative'.

Staff felt they were supported by the management team. Staff said, "We get all the support we need" and "If we are not sure of anything, there is always someone to give us support". Staff who had received supervision told us "It was very useful".

Staff had not received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a refurbishment programme in place to improve the environment. This was on-going and in progress at the time of our visit. The environmental improvements were taking into consideration lighting, safety and adaptations to promote people's privacy and dignity. Communal areas were free from obstructions which people could trip over and people could walk around the hallways and communal areas as they chose. There was, however, a lack of suitable signs placed around the environment to help people orientate themselves and find their way around.

We recommend that the provider seeks guidance and advice about best practice in ensuring the environment supports people living with dementia.

People were provided with a choice of nutritious meals. Comments about the food were positive with people telling us, "The food is marvellous. I like my food". "You get a very good choice". Other comments were the food is, 'all right', 'okay', 'nice' and one person said the meals were 'great'. Another person added, "The food is very good and homemade".

People were given a choice of three meals at lunchtime. The cook prepared suitable quantities of the three choices and people were asked what they wanted at the time of the meal. Staff said they asked people what they wanted just before the meal, because people could forget and this meant they could have what 'they fancied at the time'. Alternatives were available for people who did not want anything on the menu and this included baked potato, sandwiches, omelettes or egg and bacon. There was always a hot option available for the evening meal as well as sandwiches. A choice of desserts was on offer after each meal. Hot and cold drinks were offered with the lunchtime meal. Additional snacks and drinks were offered throughout the day and night. Cold drinks were available in jugs for people to help themselves from.

Some people had specific dietary requirements such as needing a diabetic diet or needing their meals to be pureed or of a softer consistency. The cook was aware of people's different dietary needs and meals were prepared for individual people at suitable consistencies.

Requires improvement

Is the service caring?

Our findings

All the people we spoke with told us they were happy with the care they received. People told us, "They (staff) all look after me here". "Everyone is friendly and do things for me" and, "Everyone is really good". One person said, "The staff are really calming and helpful". Relatives said that they found staff 'caring and kind'. One relative said, "I am very happy with the care they give here".

People had not been supported to express their views about how they would receive their care which did not give them the opportunity to have a say about how they wanted to be supported. There was not much information about people's choices, likes, dislikes and interests to make sure staff knew what people preferred. The care plans had very little information about people's background and life histories. One person had moved into the service and had a life history book in their file, which had been written before they moved in. Staff were not aware of this information and could not tell us about this person.

Information was not provided in ways that people, including those living with dementia, could easily understand, such as large print and pictures. There was a board where the menus for the day were written up, but this was not easy to read. There was a board in another room with a menu written on it, but this was out of date and did not reflect the meals that were on offer on the days of our visits.

Staff interactions with people varied. We spent time in the lounge and dining areas observing how staff supported and communicated with people. At lunchtime some people needed staff to help them eat their meal. Some members of staff did not talk to people when they helped them to eat their meal and sat in silence. One member of staff became distracted and helped another member of staff, and left the person without any explanation in the middle of their meal. At other times during the day, staff were focussed on people's physical needs and many interactions were task based, as staff supported people to move around or help them with a drink or a snack without any engagement with the person. People who sat quietly in their chairs and did not interact with staff were left alone and did not benefit from spending any meaningful time with staff.

The provider had not made suitable arrangements to support people with their care and treatment to ensure that people's needs were met and their preferences taken into account. This was a breach of Regulation 9 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of people who might become upset or agitated. One person became unwell at lunchtime and was visibly upset. Staff responded quickly. They reassured the person and made sure they were taken to a quiet area where a nurse could attend to their needs. Staff did not overcrowd this person and they were reassured by staff. Another person became agitated and staff were calm and patient. They listened to what the person was telling them and offered them different choices to help relieve their distress. Staff made eye contact with people and crouched down to speak with them so they were not stood over people but were at the same level.

When people needed support to move around, staff walked with them at their own pace and supported them without restricting their independence. When staff used specialist equipment such as hoists, or using wheelchairs, they told people what they were doing. One person was quite anxious when staff needed to use the hoist to move them from their chair, so staff took their time and constantly reassured the person.

Some people were chatty and talked to staff. Staff responded when people asked questions or asked for help. When staff spent time with people they spoke slowly and clearly and answered any questions calmly and patiently. Staff told us that they knew which members of staff worked well with different people. One member of staff said, "We are all people and everybody is different. I have a good rapport with (named person), but someone else might respond better to another member of staff". They went on to say, "We know about people's different needs but sometimes it's about personalities, so we always try to make sure that if people don't respond to one of us, then we will get another member of staff to help out". We observed this on one occasion when one person did not want to be supported by a member of staff. Another member of staff helped the person instead and they were happy with this.

Requires improvement

Is the service caring?

People's privacy and dignity was mainly protected, although we noted that some people occasionally walked into the communal areas in different stages of undress. Staff, however responded quickly and supported people back to their rooms to help them get dressed appropriately.

People's religious and cultural preferences were respected. People who wanted to attend church were supported to do so. One person's first language was not English and staff who spoke the same language as this person checked that they had everything they needed. One member of staff said, "I have learnt some basic key words so that helps". Another member of staff told us that they used to have some picture cards, but they had 'disappeared". They said, "It would be useful if we could find those again".

People felt they could have visitors when they wanted. Relatives told us there were no visiting restrictions and felt they could visit when they liked. Relatives commented, "We are made welcome and I always come unannounced" and "I visit regularly" and "I feel welcome". One relative told us, "I bring the dog with me, because I feel quite welcome to".

Requires improvement

Is the service responsive?

Our findings

Relatives told us that they knew records were kept and said they felt they could contribute or have a say about their family member's care. People knew about the support they received, but were not aware that they had a care plan. Staff told us that people 'did not really know' about their care plans. Although one member of staff said, "When we review the care plan, we sit with people and try to show them the care plan, but people aren't interested and aren't really sure what they are for".

There were shortfalls in the pre-admission assessments, care plans and ongoing assessments. The provider had an action plan in place with timescales to address these issues and this had not been completed at the time of our visit. Some of the records we viewed were not up to date or current. Pre-admission assessments were not always fully completed before people moved in so staff did not know how to support people in accordance with their needs. A senior member of staff visited people to carry out this assessment, but information from this was not always recorded onto the assessment. Therefore this could not be used to form a comprehensive care plan to give staff guidance about meeting people's needs.

Care plans were not always written when people moved into the service. One person had moved in in April, but the care plan had not been written until July so there had been no guidance about how to care for this person. The information in the care plans varied in detail. Some care plans contained details of people's needs and gave staff guidance about how to support people. Other plans were not up to date and did not give staff the information they needed to provide consistent care. For example changes in continence needs were not identified so the person was helped to the toilet when they needed.

Further assessments of people's needs, such as assessments of their skin health and dietary needs, had not always been reviewed to ensure that any changes in people's needs were identified. Therefore the information in people's care plans was not current and appropriate to ensure they received the care they needed. For example there was no information about how to support one person with their weight loss to ensure they did not lose any more weight. This person had then lost some more weight.

Staff told us they relied on verbal handovers from senior staff to tell them about new people who moved into the service and if there were any changes in people's needs. Staff felt that this was not always a reliable process, but were working on new systems to help them improve communication.

People were not always properly assessed before they moved into the service and peoples' assessed needs were not regularly reviewed to ensure they remained current. Care plans were not updated with changes in people's needs. This was a breach of Regulation 12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about people's current needs and staff described how they supported people. Staff made sure people were supported with their personal care and monitored people to make sure they were safe. Although care plans lacked information about what people could and could not manage for themselves, staff told us how they supported people to be independent. Some people could manage some of their own care and so staff provided encouragement rather than actually doing things for people.

People felt that staff gave them the support they needed. One person said, "You can go to bed when you like". Another person said, "I am looked after" and a third person commented, "I have a shower when I want". Relatives were complementary of the support provided by staff. One relative said, "When Dad wasn't very well they checked on him all the time, even when we were there. They always told us if anything changed". Two relatives told us about specialist equipment their family members had. Both these relatives said that staff made sure that the equipment was used properly. One relative said, "Dad needs a certain type of chair and when I visit I see that he uses it".

People told us they were not very interested in taking part in a lot of different activities. One person said, I like to do want I want" and another person said, "I can always find plenty to do. I like to sit and write letters". One person said, "I like to listen to the radio in my room". Some people told us they liked to watch films or listen to music and others said that they liked to go out.

There were limited activities taking place in the main lounge areas where most people spent their time. There was a reminiscence room which was set out with items

Requires improvement

Is the service responsive?

from days gone by and activities such as arts and crafts were based in this room. Most people needed support to use this room and during our visits, not many people were supported to use this area. There were three people using the room on one day and they were doing some artwork which they clearly enjoyed.

Staff did put episodes of an old comedy programme on the television for people to watch on the afternoon of one of our visits, but at other times there were pop radio stations playing modern music that people did not appear to be listening to. Staff were not supporting people with a choice of any other activities.

The provider had identified that activities needed to improve. An additional activities coordinator had been recruited, which meant there were more staff to support people with different pastimes. They were in the process of developing ideas and plans to expand on the range of activities available. This included shopping trips and a range of craft based activities. The provider's action plan had identified further areas for improvement and set staff targets to facilitate additional activities.

Special occasions were celebrated and a garden party had taken place. Outside entertainers visited on a regular basis. On one day a singer visited. People thoroughly enjoyed this and were singing along to the music and some people were dancing with staff. An aroma therapist visited weekly and usually saw six people at a time. One person told us they looked forward to the aroma therapists visits.

We recommend that the provider seeks advice and guidance from a recognised source about developing activities for people who are living with dementia and / or mental health conditions.

There was a complaints procedure in place. The full complaints procedure gave detailed information about how to make a complaint, who to complain to, how it would be dealt with and the timescales that it would be responded to. The complaints policy was on display in the entrance hall away from the main communal areas, so it was not readily available for people living at the service. We asked how staff supported people to raise any concerns. Staff told us that if anyone told them they were unhappy with anything they would report it to a senior member of staff. People told us they did not have any complaints and confirmed they would tell staff if they were unhappy with anything. The operations director had carried out quality assurance visits and talked to people at these visits to check if there were any concerns or complaints.

Relatives told us that if they had any concerns, they were happy to raise them with either staff or the manager. One visitor told us about a concern they had raised and how 'happy' they had been with the outcome. They said, "(My relative) prefers to be in their room and that's where they like to have their meals. I was worried about the table and the nurse sorted out a much better table. She is much safer and eats better now".

Requires improvement

Is the service well-led?

Our findings

There was no registered manager, although there was an acting manager in place who was overseeing the service. The operations director was also based at the service. This was because they had recognised that there were shortfalls. The provider was supporting the staff to address these and had put in additional resources to support the service to make improvements.

There was a vision for improvement and a number of changes were being implemented. Action plans had identified areas that needed improvement and gave timescales. For example, issues around mental capacity, Deprivation of Liberty Safeguards (DoLS), care planning, risk assessments, staff training and supervision had been identified as all needing to be improved. The operations director was overseeing the action plan, but these areas of improvement still needed further actions by staff to improve people's quality of care and experiences.

Although staff knew what their day to day responsibilities were and promoted an open and transparent culture, some staff were not always making sure that they completed the tasks they were accountable for. The action plan clearly identified who needed to take action in the different areas and this was being monitored by the senior management team so actions could be taken when staff did not complete their tasks.

The acting manager was responsible for health and safety audits and checking on the quality of care provided. These were not always being carried out as there were no audits of accidents and incidents, medicines or infection control. Some audits did not identify gaps in the records. For example, we looked at the care records for one person and found they did not have the food and fluid charts they needed to monitor their intake to make sure they kept healthy, but the acting manager's audit stated that the all the records were complete.

The provider had not ensured that the systems and processes in operation to assess, monitor and improve the quality and safety of the service were consistently applied. This was a breach of Regulation 17(2)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not well maintained to ensure that people received the care and support they needed. Some records, such as care plans and associated risk assessments were not consistently kept up to date to reflect people's current care needs. Although medicines were managed safely, the records for the returned / destroyed medicines were poorly maintained and incomplete so staff may not know which medicines had been returned or destroyed.

There were individual records and charts, associated with people's care for staff to complete, but these were not always being filled in. Some people were at risk of dehydration and needed to have their fluid intake monitored and recorded. Some records were inconsistently completed and some people, who should have had fluid charts, did not. Records associated with people's nursing needs such as blood sugar monitoring records and wound care treatment plans were not completed properly. Therefore staff could not be clear that people had received the care and treatment they needed. Senior staff were not checking to make sure these records were in place and up to date, so that people received care in line with their current needs.

Other records could not be located. The current accident book had been started on 21 June 2015 and the previous book could not be found.

Accurate and complete records in respect of each person were not maintained. Other records relating to the management of the regulated activity could not be located. This was a breach of Regulation 17 (2)(c) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to gain feedback from people and their relatives, although these had not been fully developed. Some quality assurance questionnaires had been sent out to relatives, but any responses had not been reviewed or collated. There were no formal procedures to have meetings with people, but the operations director carried out quality checks and asked different people what their opinions of the service were. These were recorded and specific requests acted on. For example, one person said they would like to have a fish tank in their room and this was arranged. People had not been asked for their opinions on the improvement works happening in the service and did not know what the refurbishment would look like.

Staff told us they wanted to improve the quality of the service provided. One member of staff said, "We need to build up our reputation and show that we can give good

Requires improvement

Is the service well-led?

care. I feel we are getting better". Another member of staff said, "We all go above and beyond. We know communication is an issue and we try to work together to improve things".

Staff were supported to question practice and raise any concerns. Actions were taken by the management team if there were any concerns about poor practice. Staff told us they felt confident that they could go to a senior member of staff or the manager and raise any issues. They told us they would not hesitate to raise any concerns.

Staff felt they were supported and attended regular meetings. Staff had the opportunity to have a say and give feedback. The operations director used the team meetings to help staff develop values and behaviours. Staff were given information about legislation and good care practices to help them improve their knowledge base and gain a further understanding of what they were responsible for. At the last team meeting staff had been invited to talk about changes they would make if they were in charge of certain areas. Staff had contributed a list of actions they would implement to help improve the quality of the service. Most staff felt they could contribute to improvements, although some staff stated that they did not feel that their opinions were always heard regarding care practices and organisation of the home.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. This is to ensure we could check that appropriate action had been taken. Untoward incidents or events had been reported and the provider told us about actions that had been taken to prevent them from happening again.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have proper procedures in place to comply with the Mental Capacity Act 2005 and to obtain consent from people for care and treatment. This was a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected against potential risks to the unlawful deprivation of their liberty. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs at all times. Staff had not received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not always properly assessed before they moved into the service and peoples' assessed needs were not regularly reviewed to ensure they remained current. Care plans were not updated with changes in people's needs. This was a breach of Regulation 9 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to make sure that risks to people staff and others had been managed to protect people from harm and ensure their safety. The provider had failed to make sure that care and treatment was provided in a safe way. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
CQC served a warning notice to the registered provider requiring them to take action to address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that the systems and processes in operation to assess, monitor and improve the quality and safety of the service were consistently applied. Accurate records were not maintained to ensure that medicines were managed properly. Accurate and complete records in respect of each person were not maintained. Other records relating to the management of the regulated activity could not be located. This was a breach of Regulation 17 (2)(a)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
CQC served a warning notice to the registered provider requiring them to take action to address this breach.